DENISON ISD AFFIDAVIT INSTRUCTIONS

INSTRUCTIONS:

1. Print your name on the top blank line, then check either the elect or do not elect box (this includes out-of-pocket premiums or payroll deducted premiums that you want to make TAX FREE).

2. Section A: If you have payroll deducted premiums that you would like to come out of your check before taxes are calculated, you must check the 'yes' box. Do not enter the amounts; we have your actual amounts.

3. Section B: If applicable, enter your OUT-OF-POCKET MEDICAL/DENTAL EXPENSES **(MONTHLY).** The IRS MAXIMUM AMOUNT is estimated to be $3,200.00 a year or $266.66 per month, with a $640.00 rollover provision.

4. Section C: If applicable, enter your DAY CARE costs calculated on a monthly basis. Maximum allowable amount is $5,000.00 per calendar year or $416.66 per month. Also, enter your Day Care provider.

5. Section D: If applicable, enter your OUTSIDE HEALTH RELATED PREMIUMS AND THE NAME OF THE CARRIER OR CARRIERS **(DO NOT ENTER ANY PAYROLL DEDUCTED PREMIUMS IN THIS BLANK).**

6. Please SIGN AND DATE.

7. We need your MAILING ADDRESS for sending any important notices or information about your plan.

8. **Last line - fill in your Campus or Location and an e-mail address as you must have an e-mail address on file with TASC in order to access your online account information.**

DENISON ISD OPTION 125/FLEX$YSTEM AFFIDAVIT

(ALL DISD EMPLOYEES MUST SIGN A FORM AND CHECK ELECT OR NOT ELECT PARTICIPATION)

SEPTEMBER 1, 2024 – AUGUST 31, 2025

I, _____, elect ☐ do not elect ☐
(Print First & Last Name)

to participate in the **Denison ISD Cafeteria Plan, which includes any or all of the following:** A (Payroll Deducted Premiums), B, C, and/or D)

	PER MONTH AMOUNT
A. Make My Payroll Deducted Premiums Tax Free	*@ Yes ☐ No ☐
B. OUT-OF-POCKET MEDICAL/DENTAL EXPENSES (IRS estimated maximum is **$3,200.00** a year or $266.66 per month with a $640.00 rollover provision)	#*$_____
C. DEPENDENT/CHILD CARE (Maximum is **$416.66** Per Month) Provider_____	#*$_____
D. PREMIUM CONVERSION (Eligible Health Related Premiums paid directly by cash, check, online, or bank draft, **not payroll deducted**) Carrier_____	#*$_____

_____ _____
(SIGNATURE) (DATE)

_____ _____ ____ _____
(ADDRESS) (CITY (ST) (ZIP)

_____ _____
(CAMPUS/LOCATION) (e-mail)

I UNDERSTAND THAT IF I FAIL TO EXECUTE A NEW AFFIDAVIT FOR ANY SUBSEQUENT PLAN YEAR, THE CURRENT AFFIDAVIT WILL REMAIN IN EFFECT UNLESS CANCELED BY ME IN WRITING.

*** THESE AMOUNTS ARE FOR THE 2024-2025 PLAN YEAR AND DURING THE PLAN YEAR, CAN ONLY BE CHANGED BY AN IRS QUALIFYING EVENT.**

Revised 7/9/2024